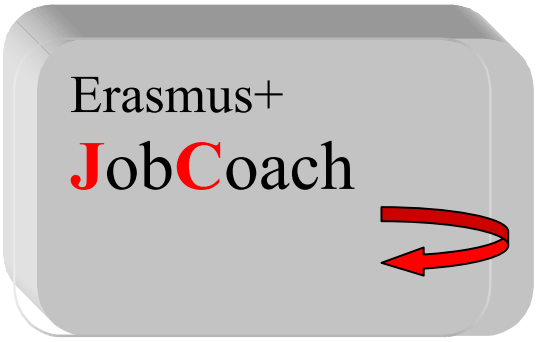
Erasmus+ - project

„Job coach for persons with disabilities”



Guideline for handling with specific disabilities

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Inhalt

These Guidelines for the employment situation and support of persons with specific handicaps (persons with disabilities) summarizes the necessary condition-specific knowledge for Job Coaches and was developed under the responsibility of the project partner Fachhochschule Münster. The following project partner directly supported the development of the product. Here are mentioned:

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Introduction

These guidelines are intended to be used in a European framework for qualification and professional standards of a Job Coach specialized to support persons with disabilities (JC/D).

In the long term, a full professionalization with unified education standards and curricular contents for JC/D should be developed.

However, for now the (yet to be fully established) profession of a JC/D comprises of experts from different disciplines, amongst others, education, social work, occupational science, administration, and health care.

A qualified JC/D requires a common knowledge base about the conditions of individuals that are in need of a JC/D.

In this handbook we decided to focus on three major clinical presentations: autism spectrum disorder, mental health disorders, and intellectual disabilities. The activities of a specialized JC/D are especially crucial for integration and success in the labour market for persons with these diagnoses.

1. Autism spectrum disorders

1.1 What is Autism?

Autism Spectrum Disorder (ASD) is the label applied to persons who experience pervasive developmental disorders that are diagnosed on the basis of specific, atypical behaviours in social communication and repetitive/restricted behaviours (APA, 2013). There are two main diagnostic systems that both recognize an ASD diagnosis: the International Classification of Diseases (ICD-10; World Health Organisation, 1992), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). Although the ICD-10 is the instrument most widely used in the European partnership countries, internationally, most of the published research is based on the diagnostic definitions within DSM (Dillenburger, McKerr & Jordan 2015). See Table 1 for examples of behaviours relevant to a diagnosis of ASD.

Table 1: Examples of behaviours observed for ASD diagnosis

Social interaction and Communication difficulties	*Restricted and repetitive behaviours*
Initiating or sustaining a conversation Reading facial expressions accurately Building and maintaining peer relations Developmental delay in language	Repetitive behaviours Restricted interests (and in some cases, special abilities) Inflexible adherence to routines Sensory issues e.g., sensory overload or distortion Difficulties with perspective taking

ASD is diagnosed according to three levels of support needs (DSM-5; APA, 2013):

- Level 1: Requiring Support
- Level 2: Requiring Substantial Support
- Level 3: Requiring Very Substantial Support.

Asperger's Syndrome is a diagnostic category used in the ICD and the DSM-IV, but not the DMS-5. Asperger's Syndrome is characterized by average or above average intellectual ability but significant social and communication difficulties and restricted/repetitive behaviours.

At present, there are no reliable biological or neurological indicators for the presence of ASD (APA, 2013). A diagnosis of autism therefore is confirmed as a result of direct behavioural observations by the diagnosing clinicians and reports from parents and other professionals.

Advances in recent genetic and neurobiological research supports the existence of 'multiple impairment models of ASD' (Bedford et al. 2014, p.612) and it seems increasingly unlikely that any single factor underlies the condition (Boucher, 2012). There is some evidence that autism

may have a genetic origin (Szatmari et al., 2007), although a large range of environmental factors may also impact on pre- and post-natal development (Medical Research Council; MRC, 2001; Rutter 2011). At present, an association between autism and vaccinations remains unconfirmed (DeStefano, Bhasin, Thompson, Yeargin-Allsopp, & Boyle, 2004; Rutter 2011), although the presence of industrial chemicals in the environment have been linked with developmental neurotoxicity (Rutter 2011) and, consequently, neurodevelopmental disorders such as autism (Grandjean & Landrigan 2014).

Individuals with autism may have a number of co-occurring conditions (Kielinen, Rantala, Timonen, Linna, & Moilanen, 2004). For example, co-occurring epilepsy has been reported to affect between 5%-38% of people with ASD (Mannion, Leader, & Healy, 2013; Tuchman & Rapin, 2002). Other frequently co-occurring medical conditions include motor difficulties, sensory impairment, Down syndrome, and cerebral palsy (Kielinen et al., 2004; Office for National Statistics [ONS], 2005). There is evidence that gastro-intestinal problems are relatively common among individuals who have autism (Mouridsen, Isager, & Rich, 2010); it is possibility that there is an association with harmful gut bacteria, such as *Clostridium bolteae*, which has been found in higher numbers in children with autism who also have gastrointestinal symptoms (Pequegnat et al. 2013). However, these findings need confirmation and interpretation; a causal relationship between non-neurodevelopmental factors and autism remains highly speculative. Mental health problems such as depression and anxiety are also frequent (Stewart, 2008; Matson & Shoemaker 2009). Although intellectual disability is not a diagnostic feature of autism, this is probably the most common co-occurring disorder (Matson & Shoemaker 2009), and has been reported to affect between 50% and 70% of individuals diagnosed with ASD (ibid.); the figures are variable, but individuals with a more severe intellectual disability (i.e. a reported IQ of <70) are thought to comprise less than half of those diagnosed with autism (Baio, 2012).

Epidemiology

The global prevalence for ASD was estimated to be 0.62% with an overall variability from 0.30%-1.16% (Elsabbagh et al., 2012). There is no evidence of geographic, ethnic or socioeconomic differences, although there are limitations of existing data sets particularly in developing countries (ibid.). The Centers for Disease Control and Prevention (CDC) found prevalence rates in the United States have risen from 1 in 110 (CDC, 2009) to up to 1 in 50 for children (CDC, 2016). The estimated prevalence rate in South Korea has been reported to be 1 in 38 (Kim et al. 2011)

In the United Kingdom (UK), a secondary analysis of the Millennium Cohort Study (n=18,000+ children born in 2000) indicated rising prevalence rates over time. Reported autism prevalence was 0.9% when the children were aged 5 years rising to 3.5% when the children were aged 11 years (Dillenburger, Jordan, & McKerr, 2014). Within Northern Ireland, the annual School

Census revealed 2.3% of school-aged children were diagnosed with ASD (ibid.)

Prevalence studies indicate that at present, males outnumber females by a ratio of approximately 1 to 4 although there are increasing concerns about the impact of gender on accurate diagnosis; current diagnostic tools may miss the presentation in females, who are likely to be diagnosed later, and generally only when more severe impairments are identified (Gould & Ashton-Smith 2011; Dworzynski, Ronald, Bolton & Happe, 2012).

The cost of autism

The most recent study of economic costs of autism in the UK and the USA (Buescher, Cidav, Knapp & Mandell, 2014) indicated that overall, the lifetime expenditure in supporting an individual with an autism spectrum condition (without intellectual disability) is £0.92 million (€1.067million), and for an individual with a co-occurring intellectual disability, up to £1.5 million (€1.74 million).Overall, the annual cost of autism provision and loss of productivity for adults is estimated to be £29-31 billion (€33.6-35.9 billion)[1] in the UK; 42% of this cost is due to lost employment opportunities for adults with autism (Buescher, et al., 2014, p.724-725).

With regards to the cost of autism in Europe, *Autism Spectrum Disorders in the European Union* (ASDEU)[2] are conducting a wide-ranging study which includes prevalence and economic cost within 12 European countries (2015-2018). This study will provide the most up-to-date figures for adult employment loss; it will also consider quality of life issues. Although there is no centralised database in Europe, some European countries have collected cost of autism data. For example, in Germany, the economic cost is thought to be around 70% of that in the UK, with a lifetime costs for a person with autism (without intellectual disability) around €766,865 (Bachmann, 2013). A study from the Netherlands estimated that €109.2–€182 billion are spent on ASD annually (Peters-Scheffer, Didden, Korzilius, & Matson, 2012), including education, (supported) work and (sheltered) living and concluded that this could be off-set by approx.. €1,103,067 per child, if Early Intensive Behavioural Interventions (EIBI (Reichow, Barton, Boyd, & Hume, 2014)) were put in place.

Autism and the working environment

Given the characteristics commonly associated with a diagnosis of autism outlined in Table 1, such as repetitive behaviours, inflexible adherence to routines, sensory issues and difficulties with perspective taking, it is not surprising that individuals may find challenges in obtaining and maintaining employment (Rosenblatt, 2008). Some may be unable to interpret colleagues' feelings or expressions, and thus appear insensitive or are thought to behave inappropriately;

[1] Dependent upon the variation in estimated prevalence figures for co-occurring intellectual disability (40-60% respectively); the figure does not include social security benefits, which the authors deem 'transfer payments and not real societal costs' - see Buescher et al. (2014, p. 724)

[2] See http://www.autismeurope.org/files/files/09h35-joaquin-fuentes.pdf for details of the programmes and funding

others may have difficulty coping with change to routine or environment, organising work and planning or predicting outcomes of their actions (National Autistic Society 2011, p.3)[3].

> *…[name] was stacking shelves somewhere and halfway through the job someone asked him to change and wipe the floor, and that was just a nightmare. In the work placements I think there could have been better autism awareness training around what stresses out people on the spectrum.'* [Parent of a young adult with autism and intellectual disabilities] (Dillenburger, McKerr & Jordan, 2015, p. 88)

Others may find that employers underestimate their capabilities and do not offer employment that makes full use of their abilities because of misconceptions about autism.

> *…[I was working in] a laptop repair shop, because one of my interests was IT, computers … I'm very interested in the technical spec of things … I like to work with an open source system, something called Linux [but] …people see computers like a black box… they just want to push the buttons … and the way they speak to me… 'No [name]... brush the floor'… I'm probably exaggerating, but…'*[Adult with Master's degree] (Dillenburger et al., 2015, p. 101)

Employers can make reasonable adjustments for the needs of individuals on the autism spectrum to enable them to become 'effective and highly valued employees' (National Autistic Society 2011, p. 5). For example, in food production, work-related activity is seasonal and weather dependent and there is no guarantee of a fixed daily routine. An employer will need to enable the employee with ASD to adjust to frequent changes in routine or allocate duties that require adjustments less frequently. Advance planning (including for 'unplanned' activities that could arise) and well developed communication strategies need to be in place as business owners recognise individuals with autism may need extra time or additional instruction.

> *And in the morning too, to help the people with autism, we'd have a white board, so you would write down, structure… what they're doing today... you know, in this climate sometimes it rains and all … You can clearly score it out, 'we are unable to do that because of the weather' and if they can't read you can draw wee symbols, it's raining, cloud, and that helps to de-stress ... because things do change.* [Business owners offering work placements] (Dillenburger et al., 2015, p. 145-6)

For some adults with ASD, the need for a more predictable or solitary environment with fewer workplace distractions may be met by self–employment.

> '*I basically found a job where people would tell me what they want … and then they would leave me alone… and I could get on with it [laughs]. So, doing [craft] is very good, you know, I'm an expert in it… it's all controlled and I don't get any paradoxical situations… I like the fact that I'm in control, with it, and it's definable, and then occasionally there's… you get a moment where what*

[3]For a more detailed view of the potential impact in the workplace, and means to address this, see http://www.disabilityaction.org/fs/doc/publications/employing-people-with-autism-a-brief-guide-for-employers-external-publication.pdf

you do far surpasses what people expect, and they come in and go 'Wow' and then, that's great.'
[Self-employed craftsman and artist]
(Dillenburger et al., 2015, p. 102)

Employment statistics

Accurate employment figures for adults with autism in the UK are presently not available. The most comprehensive information to date is derived from a survey of 1,179 adults with autism in England which suggested that only 15% of adults with autism were in full-time employment (Rosenblatt, 2008).

A small German survey of 125 adults with Aspergers' Syndrome suggests a similar situation Despite average or above average formal school and professional qualifications, only a minority of less than 20 % was in full-time jobs, many individuals were without any employment (Nedjat, Croissant, Röttgers 2011).

Clearly, many adults with an autism spectrum condition are not fulfilling their employment potential. However, public opinion is very positive regarding individuals in employment. The Northern Ireland Life and Times (NILT) Survey included a designated autism module in 2012 (total of n=1209 respondents). Very positive views were expressed about working together with adults with autism, in a variety of job positions, and for individuals without intellectual disabilities, it was felt that there were very few job-related boundaries. In fact, some 12% of respondents indicated that they would give more business to firms with an active policy of employing adults with an autism spectrum condition (Dillenburger et al., 2013;).

Some employers are already aware of the advantages of employing people with autism. The German Information Technology firm Systems Applications Products (SAP) introduced a scheme to specifically recruit adults with ASD (Guardian, 2013). The company valued the potentially enhanced abilities with regards to attention to detail and accuracy in data analysis which could be offered by individuals with autism. In Ireland, SAP have entered into partnership with the Danish organisation Specialisterne[4], who select and train adults with ASD for this employment sector in 17 countries worldwide.

Intervention

Interventions for most adults with autism focus on adaptive behaviour and are based on assistive technology, augmentative communication, or behavioural programmes (e.g. Applied Behaviour Analysis-based interventions (Anderson, Furlonger, Moore, Sullivan, & White, 2016)) to enhance skills and reduce maladaptive behaviours (Research Autism 2016). The National Institute for Health and Care Excellence (NICE, 2012) in the UK produced clinical guidance and recommended a number of interventions, including psychosocial (e.g. adaptive/lifeskills, anger

[4] http://specialisternefoundation.com/

management and job support) and ‘bio-medical‘ (pharmacological, physical and dietary) therapies.

There is a statistically significant relationship between early intensive applied behaviour analysis (ABA)-based interventions and ‘optimal outcomes‘ for children with autism, including a significant reduction in symptoms such as restricted and repetitive behaviours (MacDonald et al., 2014; Troyb et al., 2014); in turn, this can lead to improved chances of employment and reduced care needs for adults (Fein et al., 2013; Orinstein et al., 2014).Conversely, lack of appropriate early intensive behavioural interventions has been linked with extremely poor long-term outcomes (Howlin, Goode, Hutton, & Rutter, 2004; Howlin, Savage, Moss, Tempier, & Rutter, 2014) and some parents have successfully sued for damages, citing lack of these kinds of intervention (Kelly, 2014). ABA-based intervention are considered ‘treatment as usual’ in most of North America and Canada (Keenan et al., 2014) and have been linked to significant cost savings (Motiwala, Gupta, Lilly, Ungar, & Coyte, 2006).

Conclusion

Low employment rates of adults with ASD do not reflect a lack of willingness to work. In general, adults with autism want to work, however, once employment is obtained they can face additional challenges, including discrimination and/or bullying in the workplace. Consequently, after having found a job, an estimated 43% of adults with autism resign or are made redundant (Bancroft et al., 2012). Factors that can determine success in the workplace include higher IQ and competency in language (Holwerda, van der Klink, Groothoff & Brouwer 2012, p. 340). However, co-occurring mental health problems, other medical conditions, maladaptive behaviours, or intellectual disabilities can pose significant barriers to gaining and maintaining employment (Baio, 2012; Kielinen, Rantala, Timonen, Linna, & Moilanen, 2004; Matson & Shoemaker 2009; Stewart, 2008). Guidelines related to these issues should be considered in conjunction with the ASD guidelines.

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2. Intellectual disability

What is Intellectual Disability?

Intellectual disability (ID) is a notion generally used when a person has certain limitations in cognitive functioning and deficits in adaptive functioning. Intellectual disability can happen any time during developmental period, even before birth, and influences overall psychical, social and economic functioning in an adult life. The definitions of intellectual disability and related terminology have evolved over time to reflect the legal and social gains made by individuals with such a disability and their families.

The term of 'intellectual disability' is constantly used not consequently in two main classifications of mental diseases: of WHO - ISD -10 (ICD-10; World Health Organisation, 1992) and of American Psychiatric Association - DSM 5 (DSM-5; American Psychiatric Association, 2013). In the ICD -10 classifications still is used the old - fashioned term "mental retardation", as there exists a section titled "Mental Retardation" (codes F70–F79). In the next revision, the ICD-11 is expected to replace the term mental retardation with either intellectual disability or intellectual developmental disorder (Salvador et al 2011), which the DSM-5 already uses. Across the Europe, contemporary dominates the use of the term 'intellectual/mental disability', while in United Kingdom more frequent is use of the term 'learning disability'. In DSM-5 there are enumerated three types of Neurodevelopmental Disorders including: *Intellectual Disabilities, Intellectual Disability* (Intellectual Developmental Disorder) and *Global Developmental Delay. Unspecified Intellectual Disability* (Intellectual Developmental Disorder). For the purposes of this paper we have decided to use general category of **'intellectual disability' (ID) and DSM-5 approach**, which focuses on levels of support necessary to maximize an individual's skills rather than strictly on deficits in functioning. According American Association on Intellectual and Developmental Disabilities (AAIDD, 2013), ID is characterized by **three diagnostic criteria:**

- significant limitations in intellectual functioning - e.g., reasoning, learning, and problem solving;

- significant limitations in adaptive behaviour - i.e., conceptual, social, and practical skills in everyday life); and
- onset in childhood - before the age of 18 years.

Severity levels of ID: **mild** (IQ scores between 55 and 70)**, moderate (**IQ scores between 30 and 55)**, severe and profound (**IQ scores that fall under 30), as defined in *DSM-5,* **are based first on evaluation of adaptive functioning in the conceptual, social, and practical domains**. Limitations in adaptive functioning in specific skill areas are a necessary criterion for diagnosis under the AAIDD and DSM-5 definitions (APA 2013).

- ***The conceptual domain*** - includes skills in language, reading, writing, math, reasoning, knowledge, and memory;

Possible clinical signs and symptoms in this domain may include: slow language development (children learn to talk later, if at all), slow development of pre-academic skills, difficulties in academic learning (reading, writing, mathematics), difficulty understanding concepts of time and money, problems with abstract thinking (concrete approach to problem solving), difficulties in executive function (i.e., planning, strategizing, priority setting, cognitive flexibility), problems with short-term memory, difficulties with functional use of academic skills such as money management and time management.

- ***The social domain*** - refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities;

Clinical signs and symptoms in this domain, addressed to speech and communication, may include for example: imitations in language and communication skills, more concrete and less complex spoken language (if used), compared with peers, limited vocabulary and grammatical skills, receptive language that may be limited to comprehension of simple speech and gestures, communication that may occur through non-spoken means only—such as gestures, signs, facial expressions, and other forms of augmentative and alternative communication (AAC);

Clinical signs and symptoms deficits in area of social skills may include: immature social judgment and decision making, difficulty understanding peer social cues and social rules, emotional and behavioural regulation difficulties that may adversely affect social interactions.

- ***The practical domain*** - centres on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.

Clinical signs and symptoms in this domain demonstrate that person with ID requires different levels of support for daily life activities such as: personal care, more complex tasks (e.g., shopping, transportation, care organization, meals, money management), employment, health care and legal decisions, household tasks, recreational skills.

Functioning on all of three above domains determine how well an individual copes with everyday tasks, but especially the last one – practical domain, determines the severity level for ID. It is why, when diagnosing intellectual disability, the clinical assessment of the adaptive functioning is first considered, and only secondary – the IQ test score which has to be at least two standard deviations or more below the population, which equals an IQ score of about 70 or below. The adequate psychological assessment of the adaptation across three domains: conceptual, social, and practical is especially important in the development of a treatment and development plan of individual with diagnosed ID.

ID is usually well diagnosable, but it has to be mentioned that cross-cultural attitudes and beliefs about ID may influence the process of identification the particular case in this big clinical group (Allison & Strydom, 2009; Scior, 2011).

Individuals with ID are very heterogeneous group, and their communication skills can vary due to the severity level, co-occurring conditions, and other behavioural, emotional, and social factors. There are common syndromes of ID depended on a specific aetiological factors. Generally, there are prenatal, perinatal, and postnatal causes of ID:

- ***Prenatal causes of ID*** represent for example:

Genetic syndromes (e.g., Down syndrome and Fragile X syndrome); inborn errors of metabolism; brain malformation (e.g., microcephaly); maternal disease (e.g., placental disease); environmental influences (e.g., alcohol, other drugs, toxins, teratogens)

- ***Perinatal causes of ID*** include for example:

Labour and delivery – related events leading to neonatal encephalopathy (complications during labour and birth, such as a baby not getting enough oxygen, etc.); anoxia at birth

- ***Postnatal causes of*** ID are for example:

Hypoxic ischemic injury; traumatic brain injury; infections ; demyelinating disorders; seizure disorders (e.g., infantile spasms); severe and chronic social deprivation; toxic metabolic syndromes and intoxications (e.g., lead, mercury)

Genetic causes are responsible for app. 45% of ID cases (Batshaw, Roizen, & Lotrecchiano, 2013). Down syndrome is the largest genetic cause of ID, and Fragile X

syndrome is the largest inherited cause of ID. Fetal alcohol syndrome is the largest environmental cause of ID. Some prenatal causes (e.g., environmental influences) are preventable.

The disorder is considered chronic and often co-occurs with other mental conditions like depression, attention-deficit/hyperactivity disorder, and autism spectrum disorder (APA, 2013). Persons with ID may have more health problems than others in the general population. Usually it is a result of inadequate health care, limited access to quality services (Krahn, Hammond, & Turner, 2006), and communication limitations (Gentile, Cowan, & Smith, 2015). Associated health conditions with a higher prevalence in individuals with ID include: anxiety disorders, hearing loss, heart conditions, obesity-related problems, seizure activity, visual impairment and other. Addressing health inequalities and providing adequate health care and medical training can significantly improve quality of life and increase longevity in individuals with ID.

Epidemiology

Intellectual disability is the most common developmental disability. The determination of incidence and prevalence of ID is quite complicated because researchers of ID do not use the same operational definition when selecting and identifying individuals with ID[5]. Overall estimation says approximately 1-3 percent of the global population has an intellectual disability, it means as many as about 200 million people. Intellectual disability is significantly more common in low-income countries – 16.41 in every 1,000 people. The meta-analysis of international study published in 2011 found the ID prevalence of individuals across the life span is 10.37/1000 or 1.04% (Maulik et al., 2011). According to those data there are about 4.2 million persons with the disease in Europe in ages 0 to 65[6]. More recent data, extending this study and published in 2016, found ID prevalence of children/adolescents and adults to range from .05 to 1.55% (McKenzie, Milton, Smith & Ouellette-Kuntz, 2016). For European population, the

[5] Some authors use the terms intellectual disability and developmental disability interchangeably, but the latter one can include also conditions like ASD and developmental language disorder. In some cases, an IQ cut-off score is used (e.g.70) as a criterion for diagnosis, whereas in other cases, the diagnostic criteria are more qualitative in nature (e.g. onset in childhood with limitations in adaptive behaviour and intellectual functioning).

[6] Data estimated using a prevalence rate estimate of 1%, based on a recent meta-analysis indicating a prevalence rate of 0.92% in developed countries from study of Maulik et al., 2011.

average estimation of ID in 2010 (Wittchen et al., 2010, p.664-5) was assumed on 10.00/1000 with higher prevalence for middle-income countries (15.94 in compare with 7.86 for western Europe) and also indicated the number of 4,2 million persons with ID. The higher estimation for lower income countries was influenced by lack of sufficiently reliable studies from those countries and the suggestion about possible influence of environmental/ social risk factors on cause of ID – especially on their mild level forms. Such factors as alcoholism, lead exposure, iron deficiency, malnutrition, perinatal problems and many other non-genetic conditions play a major role in the excess of people with mental retardation in less economically developed countries (Bertelli et al., 2009).

The cost of ID

First results of a comprehensive study estimating the cost of disorders in Europe of the brain have indicated at the amount of €386 billion in 2004, distributed over 12 diagnostic groups of important disorders of the brain affecting 127 million adult Europeans (Andlin-Sobocki et al., 2005). In 2010 total European cost of brain disorders was already €798 billion, of which direct health care cost had 37%, direct non-medical cost - 23%, and indirect cost - 40% (Olesen et al 2012). In this study total annual cost in case of intellectual disability (mental retardation in ICD -10) was estimated on 43.3 mln €. In a benchmark European study of 2010 were showed similar results for disorder of "mental retardation" (Wittchen et al., 2010, p.736):

Cost type	2010 annual costs per patient (in €)	2010 total costs (in milion €)
Direct healthcare costs	6970	29,204
Direct non-medical costs	3364	14,097
Total costs	10 334	43,301

Authors mention that above calculation of costs does not include most of direct non-medical costs due to the disease, such as the extra resources needed in educational and social service sectors. Neither does it include indirect costs in terms of lost productivity. Considering that employment rate is very low among individuals with ID and that this diagnosis is usually associated with significant health problems such as multiple disabilities and other medical conditions - the total economic cost of ID in even more higher.

ID and the working environment

Individuals with diagnosis of ID on mild level are usually graduates of the "special schools" which have the program of pre - primary school and some of them continuing education on lower vocational level. The highest level of education or training in case of ID individuals or training attained is ISCED 0, 1 or 2[7]. The level of education generally determines their possibility to be employed, but there are also important individual characteristics' of communication and adaptive skills as well as the health status quo of particular person.

They can work in supported employment system or in sheltered work circumstances, usually carrying out relatively simple tasks under expert supervision. Sheltered workplaces, including copy centres or packing facilities, often focus on simple product assembly or the performance of a few easy tasks, such as bulk mailing, etc. Such work can be even delivered with individuals with moderate level of ID. Very often, especially in a local communities grocery stores, garden centres and small businesses hire people with mild ID level. Companies offering jobs for persons with ID usually provide cleaning or landscape services, may provide commercial services to businesses, or include production, packaging and distribution. Very good experiences flies from employment of individuals with Down syndrome to care off elder people as assistants for spending with them free time.

The advantage of ID persons at work is that they are rather stable and consistent in their performance and work with high level of motivation.

Employment statistics

Employment rates of people with disabilities are generally low in Europe, and the situation for people with intellectual disabilities is even worse. Rates of employment for overall group of people with mental health problems in Europe vary from 18% to 30%. Figures from Member States suggest that in some countries more than 80% of people with intellectual disabilities remain unemployed[8]. In other countries, the employment rate is higher due to the provision of sheltered workplaces, but here the majority of workers have no employee status. The employment rate of people with intellectual disabilities in the open labour market is extremely low in all EU countries. The main barriers in access of the people with ID to employability are connected

[7] Level 0 - pre-primary education, L1 - primary education, L2 lower secondary education

[8] For example: of the 26.786 adults with a Learning Disability known to local authorities in Scotland in 2014 only 1.782 were listed as in employment with only 875 listed as being in open, paid employment. The majority of adults with intellectual disabilities in Cyprus are rather unemployed (84%) or underemployed.

with[9]:

- **Outdated legal capacity legislation** in many European countries - without the capacity to sign work contracts, people with intellectual disabilities cannot legally work. If they live in residential institutions or work in sheltered workplaces, they often do not earn a real salary or their salary is kept by the institution;
- **Common indirect discrimination** against people with intellectual disabilities in recruitment. School leaving certificates are requested even if there is little or no connection to the job in question. Thus, people with intellectual disabilities are excluded from jobs they could perform with little or no support. This is increased by the lack of knowledge about reasonable accommodation measures and a lack of support services. Even where job coaches or other support services exist, they are mostly unknown to potential employers;
- The pitfall of **'benefit trap'** - legislation about social benefits in most Member States does not allow people to return to a disability benefits scheme after they have worked in open employment. This creates a huge barrier for persons with intellectual disabilities who may want to try working in the open labour market;
- **Lack the appropriate skills of people with ID** and - for the smooth transition from school to working life, weaknesses exist in relation to the acquisition of professional and social skills.
- **Not enough accessible work places** – employers are reserved to employ people with ID , even if they are offered with benefits of supported employment policy
- **Pay gap** among persons with intellectual disabilities and other workers.

The employers on open labour market mostly avoid to offer employment possibility to individuals with ID and persons with ID are not able to copy for such opportunity. They are usually employed in supported employment schedule.

Intervention

The goal of treatment in case of ID is to minimize the potential debilitating effects of disabilities on client and their families and to maximize the likelihood of desirable outcomes which may improve her/his adaptive behaviour. As indicated by AAIDD (2013), a persons' level of life functioning may improve only if appropriate **personalized support** is provided over a sustained period.

Authors generally support the provision of **communication intervention** for individuals with ID (Sevcik & Romski, 2016; Snell et al., 2010). Because of the variety of unique profiles of persons with ID, necessary is to access the initial level of language functioning as well as functioning in areas related to language and communication, including hearing, cognitive level, speech production skills, and emotional status. In all cases intervention considers coexisting strengths and needs in all areas to ensure individualized treatment and supports. Communication intervention focuses on the context of interactions and includes individuals that persons with ID encounter in their natural environments. Speech and language pathologists (SLPs) ensure that

[9] *Inclusion Europe's contribution to the mid-term review of the European Disability Strategy*, online: http://inclusion-europe.eu/wp-content/uploads/2015/03/IE_submission_EDS_final1.pdf, p.8-9.

intervention provides ample opportunities for communication and incorporates a variety of language functions (e.g., greeting, commenting, requesting); multiple partners; different forms and modalities of speech and varied communication contexts (e.g., home, educational, recreational, vocational, and community settings).

Various treatment options use *technology and support systems* in conjunction with functional training of communication/social skills and other target behaviours. For example:

- *Augmentative and alternative communication (AAC)* – offers supplementing, or using in the absence of, natural speech and/or writing with aided (e.g., picture communication symbols, line drawings, Blissymbols, and tangible objects) (Beukelman & Mirenda, 2013);
- *Activity schedules/visual supports* **-** include objects, photographs, drawings, or written words that act as cues or prompts to help individuals complete a sequence of tasks/activities, attend to tasks, transition from one task to another, or behave appropriately in various settings and to initiate or sustain interaction which are called *scripts.* Scripts promote social interaction and can be used in a classroom setting to facilitate academic interactions and engagement (Hart & Whalon, 2008);
- *Computer-based instruction* **-** the use of computer technology (e.g., iPad) and/or computerized programs to teach communication and social skills (Neely, Rispoli, Camargo, Davis, & Boles, 2013);
- *Video modelling* **-** video recordings of desired behaviours are observed and then imitated by the individual, learners self-modelling can be videotaped for later review.

Useful are also different **behavioural interventions** and techniques (e.g., different reinforcement, prompting, fading, and modelling) designed to reduce problem behaviours and teach functional alternative behaviours using the basic principles of behaviour change. Most common interventions useful both for children as for adults with ID include:

- *Applied behaviour analysis (ABA***) -** a treatment approach that uses principles of learning theory to bring about meaningful and positive change in behaviour. ABA techniques help build a variety of skills like: communication, social skills, self-control, and self-monitoring (Spreckley & Boyd, 2009).
- *Functional communication training (FCT)* - an intervention that combines the assessment of the communicative functions of problem behaviour with ABA procedures to teach alternative responses. FCT is used across a range of ages and regardless of cognitive level or expressive communication abilities (Carr & Durand, 1985).
- *Incidental teaching* **-** naturally occurring teaching opportunities are provided based on the individuals interests, attempts to communicate are reinforced as these attempts get closer to the desired communication behaviour (McGee, Morrier, & Daly, 1999).

- *Time delay*— the time delay between initial instruction and any additional instruction or prompting is gradually increased as the individual becomes more proficient at the skill being taught. Method can be used with individuals regardless of cognitive level or expressive communication abilities (Liber, Frea, & Symon, 2008).

A special kind of approaches is used for youth and adults with ID who are being prepared for acquiring the skills necessary for independent living and achieving success in postsecondary education/training programs, employment settings, and variable social situations. They need continued support to facilitate a successful transition to adulthood. Therapists are involved in their transition planning and may be also involved to varying degrees in other support services beyond high school. The special kind of support is offered for aging adults with the goal to maximize their independent functioning. The aging process may be premature in adults with ID as compared with the general population (Lin, Wu, Lin, Lin, & Chu, 2011) and for example, individuals with Down syndrome may be at higher risk for earlier onset of dementia when compared with the general population (Burt et al., 2005). Even when dementia is not taken into account, speech and language skills may begin to decline in adults with ID from about the age of 50 (Roberts et al., 2007). Some adults with ID, particularly those with psychomotor impairments or other co-morbid conditions that affect feeding and swallowing may experience dysphagia-related problems as they age (Lazenby-Paterson & Crawford, 2014). General treatment rules in case of ID advocate for:

- Using family-centred and culturally appropriate practises.
- Forming collaborative teams.
- Following a strength-based perspective.
- Maximizing self-sufficiency.
- Recognizing individual variability.
- Fostering a community environment of respect and inclusion.
- Using natural environments.
- Involving peers as communication partners.

designed to enhance peer interactions in the settings in which adults live, work, or socialize have shown that continued support can lead to enriched social functioning. For example, interventions such as **job coaching,** partner training, and social facilitation can improve interactions of intellectually disabled individuals in the workplace (Mautz, Storey, & Certo, 2001).

Conclusions

'Enable many more people with disabilities to earn their living on the open labour market'[10]

Low employment rates of persons with ID are due to understandable obstacles on side of employers, but also on side of not efficient support system. Lack of sufficient communication skills and adaptive skills connected with different health complications are main reasons why persons with ID have limited chances for employment on open labour market. However, especially group with mild level of disability has the work potential which can be prospectively used by organizations. There is a scope of simple tasks individuals with ID are able to do and they would do with high engagement. The schedule of supported employment and assistance of job coaches is here very welcomed. Organizations should develop their non-discriminatory recruitment methods to be more opened on this group of potential employees and enforce external services to help them with employing people with intellectual disabilities. In the current labour market, where it is hard and harder find dedicated workers for performing simple tasks it seems to be quite obvious. There is also essential to recognise all legal capacity legislation that hinders access to employment as direct discrimination against people with intellectual disabilities.

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3. Psychiatric disorders

3.1 General remarks

This chapter covers a variety of psychiatric disorders defined by their ICD classifications.

We decided to focus on
-schizophrenia
-affective disorders
-anxiety disorders
-obsessive-compulsive disorders

in this handbook. We do not underestimate the influence of other psychiatric disorders on the health status, wellbeing and occupational situation of people. However, each of the conditions mentioned above "qualifies" for a special focus in our view. On one hand, we deal with frequent disorders like anxiety and OCD that many JC/D will be confronted with, especially because there are common misunderstandings about their treatment and outcome. Scientifically sound knowledge will not only be in the best interest of the client but also of colleagues and employers.

On the other hand, schizophrenia and affective disorders tend to be long-term, recurrent and/or chronic conditions. Those conditions have a lifelong impact on the occupational situation; profound and sound knowledge of a JC/D may and should contribute to successful placements and well-adapted workplaces for important periods of the clients' lifespans.
A JC/D is no psychiatrist; so, of course, we do not expect JC/D to act as such. The informations given here focus on general knowledge and on those symptoms and behaviours that have
a) a direct impact on the job situation and/or employability
b) need specific support and/or intervention in a workplace situation

c) may indicate a change in the course of the psychiatric condition so that, among others, an employer, colleagues or a JC/D may refer the client to his or her psychiatrist or even take emergency measures according to the respective national laws.

We furthermore suppose that a JC/D knows the exact diagnosis and medical background of the employed person. This is most helpful to be able to individualize and custom-tailor support. In reality, the availability of information will depend on data protection regulation and above all on the quality of the personal relationship betwenn JC/D and client: under all circumstances, the autonomy of the client has to be respected. Only if and as long as a client sees the support of the JC/D as an important positive element for the employment situation, he or she will agree on sharing crucial personal information.

3.2 Schizophrenie

Die Schizophrenie zählt mit einer Lebenszeitprävalenz von ca. 1 % zu den häufigsten psychischen Erkrankungen, mit ihren charakteristischen, für den Außenstehenden oft schwer nachvollziehbaren Symptomen prägen sie die Vorstellungen von psychischen Erkrankungen allgemein. Schizophrene Erkrankungen betreffen alle Kulturen und geographischen Regionen, das Risiko ist vor allem genetisch determiniert. Dass heißt, dass in bestimmten Familien das Erkrankungsrisiko deutlich starker ausgeprägt ist. Auf dem Boden der genetischen Disposition führen dann externe Belastungen zum Krankheitsausbruch, das typische Ersterkrankungsalter liegt zwischen 20 und 30 Jahren, Männer erkranken früher, ein wesentlicher Faktor für Erstmanifestation und Rückfall ist vor allem bei jungen Menschen der Cannabiskonsum[11]. Damit betrifft eine solche Erkrankung Menschen am Beginn ihrer Ausbildung, des Studiums oder des Berufs und wirkt sich nachhaltig auf das Erwerbsleben aus.
Nach den Kriterien der ICD-10 sind Schizophrenien vor allem durch Störungen des Denkens und der Sinneswahrnehmungen gekennzeichnet; dramatische Symptome sind Halluzinationen in Form von Stimmenhören, die wahnhafte Fehlverarbeitung der Realität und ein Denkablauf, der für Außenstehende schwer oder nicht nachvollziehbar ist.

[11] Schöler et al 2016

Schizophrenien können sich auf eine einmalige Episode beschränken, in der Mehrzahl der Fälle kommt es aber zu weiteren Krankheitsphasen. Die klinische Erfahrung spricht dafür, dass in vielen Fällen jede weitere Krankheitsepisode die beruflichen Fähigkeiten fortschreitend beeinträchtigt.
Die Behandlung stützt sich vor allem auf die Pharmakotherapie mit den sogenannten Neuroleptika, die bei einer Ersterkrankung in den meisten Fällen mindestens ein bis zwei Jahre, bei wiederholten Krankheitsphasen über Jahre beibehalten werden sollte.
Allerdings sind die Medikamente mit individuell verschiedenen, teils belastenden unerwünschten Nebenwirkungen verbunden, so daß die Compliance sehr wechselnd ist.

Als Risikofaktoren für eine Wiedererkrankung sind vor allem das unabgesprochene Absetzen der neuroleptischen Medikation zu benennen, als weiteres der Konsum psychoaktiver Substanzen. Hier liegt der Schwerpunkt der Betreuung vor allem auf Seiten des behandelnden Psychiaters, der im Idealfall eng mit dem JC kooperiert.
Allerdings kommen auch arbeitsplatzbezogene Einflüsse als Risikofaktoren in Frage:
Die meisten schizophrenen Menschen profitieren von einem regelmäßigen Tag-Nacht-Rhythmus, so dass (Wechsel-)Schichtarbeit vermieden werden sollte.
Auch soziale Belastungsfaktoren können eine Rolle spielen: Settings wie Großraumbüros bergen das Risiko, als Stressor zu fungieren. Einzelarbeitsplätze und räumliche Rückzugsmöglichkeiten sollten optional vorhanden sein.

Im Arbeitsleben wirken sich vor allem die chronischen Aspekte schizophrener Erkrankungen aus, die oftmals auch nach Abklingen der akuten Symptome weiterbestehen. Man spricht hier (im Gegensatz zu den “Positivsymptomen” wie Wahn und Halluzinationen, die im Denken gesunder Menschen nicht vorkommen) von den sogenannten Negativsymptomen. Dazu zählen Antriebsstörungen und scheinbare Motivationsprobleme, aber auch neuropsychologische Defizite in den sogenannten exekutiven Funktionen (Handlungsplanung, -Initiierung, -Durchführung und Ergebniskontrolle).
Ein skills assessment vor Aufnahme einer Tätigkeit oder Veränderung eines Anforderungs-profils ist hilfreich, um Überforderungssituationen zu vermeiden.

Für Jobcoaches sind daher in der Begleitung schizophren Erkrankter folgende Aspekte von besonderer Bedeutung:

Zur Erkrankung:
-handelt es sich um eine wiederkehrende Erkrankung ?
-ist die betreute Person in psychiatrischer Behandlung ?
-werden die verordneten Medikamente regelmäßig eingenommen ?
-gibt es typische Früh- und Vorpostensymptome, die in der Vergangenheit einem Rückfall oder einer Wiedererkrankung vorausgegangen sind ?
-gibt es für solche Fälle einen “Krisenplan” ?
Zum Arbeitsalltag:
-wie war das Leistungsvermögen vor der Erkrankung ?
-wie stark sind die og. “Negativsymptome” ausgeprägt ?
-sind neuropsychologische Defizite bekannt ?
-existieren Sonderbelastungen wie wechselnde Arbeitszeiten, laute/unruhige Umgebungen, Nacht- oder Schichtarbeit ?
-sind Arbeitgeber, Vorgesetzte, betriebliche Gesundheitsdienste und Kollegen über die Erkrankung informiert und wenn ja, in welchem Umfang ?

3.3. Affektive Erkrankungen

Affektive Erkrankungen, andere Bezeichnungen sind “Affektive Psychosen” oder “manisch-depressive Erkrankungen”, gehen mit Störungen von Gefühl, Stimmung und Antrieb einher und äußern sich in polar entgegengesetzten Veränderungen des Affektes. Man unterscheidet nach dem gehobenen oder dem herabgedrückten Affekt die manische und die depressive/melancholische Symptomatik. Parallel zur Stimmung verändert sich der Antrieb: er ist in der Depression vermindert, in der Manie verstärkt, das allgemein Aktivitätsniveau im letzteren Fall also erhöht. Sie verlaufen in zeitlich abgesetzten Phasen, die in der Regel vollständig remittieren (also gibt es teils jahrzehntelange symptomfreie, “gesunde” Intervalle), und neigen zu Wiedererkrankungen, ohne dabei wesentliche Persönlichkeitsveränderungen oder Defizite zu hinterlassen. Hiermit unterscheiden sie sich von den Schizophrenien.

Der Begriff der affektiven Erkrankung wurde geprägt, um die negativen Assoziationen des älteren Terminus der „manisch-depressiven Erkrankung“ zu vermeiden. Außerdem ist er exakter: „manisch-depressive Erkrankung“ legt nahe, daß jeder Betroffene beide Krankheitsausprägungen, nämlich die manische und die depressive Symptomatik, erlebt. Dies trifft jedoch nicht zu. Vielmehr verläuft ein großer Teil der Erkrankungen

„unipolar“: alle Phasen der Erkrankung bei einem Menschen sind dann ausschließlich depressiv (relativ häufig) oder ausschließlich manisch (wesentlich seltener). Dementsprechend wird ein Erkrankungsverlauf mit beiden Ausprägungen als „bipolare“ Störung oder Affektpsychose bezeichnet.

Man unterscheidet jeweils unterschiedlich schwere Ausprägungen der depressiven oder manischen Phase (“leichte”, “mittelgradige”, “schwere” Episode); wenn wahnhafte Vorstellungen hinzukommen, handelt es sich um eine “schwere Episode mit psychotischen Symptomen”. Während bei leichten und je nach Motivation und Umfeldfaktoren auch bei mittelgradigen Episoden die Arbeitsfähigkeit grundsätzlich erhalten ist, ist eine schwere Krankheitsepisode mit Erwerbstätigkeit nicht vereinbar und muß oftmals stationär behandelt warden. Unmittelbarer Anlaß dazu bei depressiven Menschen ist häufig die Suizidalität. Menschen mit manischen Erkrankungen erleben sich allerdings in der Regel selbst nicht als “krank”, sondern eher als besonders aktiv, kreativ und produktiv, auch wenn dies objektiv nicht zutrifft und die Erkrankung schwerwiegende finanzielle und persönliche Fehlentscheidungen nach sich zieht. Eine Behandlung ohne den Willen des Patienten ist allerdings je nach rechtlicher Situation nicht oder nur unter besonderen Umständen möglich, so daß es zu extremen Belastungssituationen für Angehörige, aber auch Arbeitskollegen kommen kann. Wichtig ist es, nach dem Abklingen der akuten Symptome herauszustellen, dass es dabei sich um krankhaft bedingte und nicht etwa um vorwerfbare Verhaltensweisen handelte.

Die affektiven Psychosen kommen in allen ethnischen Gruppen und in allen Gesellschaften etwa gleich häufig vor.

Die Prävalenz (alle Formen eingeschlossen) wird mit 0,5 bis 2 % angegeben, das Lebenszeitrisiko liegt bei etwa 1 %. Insgesamt überwiegen die Frauen. Dieses Übergewicht ist auf häufigere depressive Phasen zurückzuführen, während manische Phasen bei Männern genauso häufig wie bei Frauen sind. Eine klare genetische Komponente ist gesichert; es gibt familiare Häufungen affektiver Erkrankungen.

Die meisten Erkrankungen beginnen im dritten und vierten Lebensjahrzehnt. Wenn die erste Phase eine manische Phase ist, tritt diese im Schnitt früher auf; bipolare Erkrankungen beginnen tendenziell ebenfalls früher und können bereits vor dem 20. Lebensjahr auftreten.

Nur gelegentlich lassen sich auslösende Ereignisse für Wiedererkrankungen identifizieren; anders als Belastungssstörungen verlaufen affektive Erkrankungen oftmals biologisch-eigengesetzlich.

Die Behandlung leichter und mittelgradiger depressiver Episoden erfolgt vor allem psychotherapeutisch. Die besten Ergebnisse liegen für die kognitive Verhaltenstherapie vor. Bei mittelgradigen Episoden können antidepressive Medikamente zusätzlich hilfreich sein, bei schweren Depressionen sind sie die Regel.

Da Antrieb und Stimmung gestört sind, neigen Hausärzte und Allgemeinmediziner häufig zu raschen Krankschreibungen auch bei leichten und mittleren Formen: auch wenn der Gedanke der “Schonung” lobenswert ist, fördert dies doch Rückzug und Isolation; zudem

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fehlen den Betroffenen Kontakte, Sinnfindung und Erfolgserlebnisse am Arbeitsplatz. Nach schweren Krankheitsphasen mit Arbeitsunfähigkeit kann ein individualisierter Wiedereinstieg mit allmählich steigender Belastung ("stufenweise Wiedereingliederung") hilfreich sein.

Akute manische Phasen werden vor allem pharmakologisch mit Neuroleptika behandelt; eine Psychotherapiemotivation im engeren Sinne besteht bei akuten Manien nicht.

Da sowohl depressive wie manische Erkrankungen zu Rezidiven neigen, wird je nach individuellem Verlauf neben der Akutbehandlung nach wiederholten Erkrankungen auch eine medikamentöse "Phasenprophylaxe" mit Substanzen aus der Gruppe der "mood stabilizer" empfohlen und hat sich in vielen Fällen sehr gut bewährt.
Wichtig ist, dass keine der genannten Medikamentengruppen Antidepressiva, Neuroleptika oder Mood Stabilizer/Phasenprophylaktika eine Abhängigkeit erzeugt. Diese verständliche, aber definitive unbegründete Sorge der Patienten führt gelegentlich zu Behandlungsabbrüchen: hier sollten alle Professionellen als seriöse Ratgeber fungieren.

Für Jobcoaches sind in der Begleitung affektiv Erkrankter folgende Aspekte von Bedeutung:
Zur Erkrankung:
-handelt es sich um eine wiederkehrende Erkrankung ?
-gab es in der Vergangenheit depressive, manische oder beide Ausprägungen ?
-ist die betreute Person in psychiatrischer Behandlung ?
-werden die verordneten Medikamente regelmäßig eingenommen ?
-gibt es typische Früh- und Vorpostensymptome, die in der Vergangenheit einem Rückfall oder einer Wiedererkrankung vorausgegangen sind ?
-gibt es für solche Fälle einen "Krisenplan" ?
Zum Arbeitsalltag:
-wie war das Leistungsvermögen vor der Erkrankung ?
-wie kann eine stufenweise Wiedereingliederung nach Abklingen einer Akuterkrankung gestaltet warden ?
-existieren Sonderbelastungen wie wechselnde Arbeitszeiten, laute/unruhige Umgebungen, Nacht- oder Schichtarbeit ?
-gibt es im Arbeitsalltag krankheitsspezifische Gefährdungssituationen (z.B. im Blick auf Suizidalität oder Risiken bei einer Manie) ?
-sind Arbeitgeber, Vorgesetzte, betriebliche Gesundheitsdienste und Kollegen über die Erkrankung informiert und wenn ja, in welchem Umfang ?

3.4. Angsterkrankungen

Angsterkrankungen sind neben Sucht und affektiven Erkrankungen die häufigsten psychischen Störungen. Man unterscheidet drei Haupttypen der Angsterkrankungen:
Bei den Phobien handelt es sich um umschriebene objekt- oder situationsbezogene Ängste. Bekannt sind beispielsweise Phobien mit Bezug auf bestimmte Tiere (Hunde, Spinnen) oder Situationen (soziale Phobien).
Anders stellt sich die sogenannte generalisierte Angsterkrankung dar: Hier können gerade keine spezifischen Auslöser identifiziert werden; der Betroffene leidet vielmehr an einer Angst "vor allem", die sich auch als "Angst vor der Angst" darstellen kann.
Die dritte große Art der Angsterkrankungen sind die Panikstörungen. Hier führen akute Angstschübe zu attackenartigen Situationen, in denen der Patient zu sterben glaubt; vor der Identifikation als psychisch bedingt muß z.B. der Verdacht auf eine Herz-Kreislauf- oder Stoffwechselerkrankung ausgeschlossen warden.
Menschen mit Angsterkrankungen reagieren typischerweise mit Vermeidungsverhalten: Sie versuchen Situationen, in denen in der Vergangenheit Angst aufgetreten ist, auszuweichen. Dieses Vermeidungsverhalten kann sich bis zur völligen Isolation und Rückzug ausweiten. Eine weitere Gefahr ist die der Suchtentwicklung: nicht erkannte und/oder behandelte Angstpatienten versuchen, mit legalen (Alkohol, Beruhigungsmitteln) oder illegalen Drogen das unangenehme oder unerträgliche Empfinden zu dämpfen oder zu verhindern.

Für alle Angsterkrankungen gilt, dass sie im Prinzip gut behandelbar sind; nach einer erfolgreichen Behandlung verbleiben keine Defizite und dauerhaften Einschränkungen. Die psychotherapeutische Behandlung in Form einer kognitiven Verhaltenstherapie ist in der Mehrzahl der Fälle rasch erfolgreich; bei vielen Patienten werden nach Psychoedukation und kognitiven Elementen Konfrontationsübungen durchgeführt. In einer idealen Welt sollte daher der Einsatz eines JC für Angstpatienten gar nicht erforderlich sein.
Tatsächlich existieren vielfältige aufrechterhaltende Faktoren, die einer Chronifizierung und Ausweitung von Angsterkrankungen Vorschub leisten. Diese aufrechterhaltenden Faktoren liegen neben Mängeln im Versorgungssystem (Mangel an qualifizierten Psychotherapeuten, unkritische Verschreibung von Beruhigungsmitteln mit der Gefahr einer Abhängigkeitsentwicklung) oftmals auch im persönlichen Bereich: Angehörige versuchen, die erkrankten Personen durch Schonung, Entbindung von Verpflichtungen und Übernahme von Verantwortung zu entlasten. Dieser menschlich verständliche Reaktion führt allerdings eher zu einer Chronifizierung und zur Ausweitung des Vermeidungsverhaltens. Im Extremfall verläßt ein Angstkranker den subjektiv "sicheren" Familienkreis nicht mehr und vermeidet so angstauslösende Situationen. Damit verliert er aber auch die Möglichkeit korrigierender

Erfahrungen und das Erleben, dass die vermeintlich gefährlichen Objekte und/oder Situationen faktisch keine Gefahren darstellen.

Im Arbeitsleben führen Angsterkrankungen in ungünstigen Fällen zu langen Krankschreibungen und Arbeitsunterbrechungen; auch hier können Kollegen analog zu Angehörigen ungewollt die Störung aufrechterhalten.

Wenn Menschen mit Angsterkrankungen nach langem Verlauf in das Arbeitsleben zurückkehren, ist das zugrundeliegende Prinzip das der Normalität. Angsterkrankungen hinterlassen keine Dauerschäden oder Fähigkeitseinschränkungen; bei ehemaligen Angstpatienten gibt es keine Ausschlüsse bestimmter beruflicher Tätigkeiten.

Wenn ein Jobcoach als persönliche Assistenz im Arbeitsleben installiert wurde, sollte er sich daher möglichst bald “überflüssig” machen; eine Dauerassistenz aufgrund einer Angsterkrankung ist kontraproduktiv.
Ein Jobcoach kann für Kollegen und Arbeitgeber aber eine wichtige Rolle spielen, indem er – immer in Absprache mit dem Betroffenen- auf die “Fallen” hinweist, in denen man unabsichtlich geraten kann, wenn man mit bester Absicht auf Krankheitssymptome mit Schonung und Entlastung statt mit aktiver Unterstützung, therapeutische Hilfe zu suchen, reagiert. In lernpsychologischer Begrifflichkeit würde man damit ein Vermeidungsverhalten positiv verstärken und damit die erneute Entwicklung der Angstsymptomatik fördern.

Für Jobcoaches sind daher in der Begleitung an Angsterkrankungen leidender Menschen folgende Aspekte von Bedeutung:
Zur Erkrankung:
-handelt es sich um eine wiederkehrende Erkrankung ?
-gab es in der Vergangenheit komplizierende Faktoren, etwa eine Substanzabhängigkeit ?
-ist die betreute Person in psychiatrischer und psychotherapeutischer Behandlung ?
-gibt es typische Vermeidungsverhaltensweisen ?
Zum Arbeitsalltag:
-gibt es am Arbeitsplatz Faktoren, die in der Vergangenheit Anlaß oder Auslöser von Angst waren ? Dies können etwa Autofahrten oder bestimmte Kundenkontakte sein.
-sind Arbeitgeber, Vorgesetzte, betriebliche Gesundheitsdienste und Kollegen über die Erkrankung informiert und wenn ja, in welchem Umfang ?

3.5. Zwangserkrankungen

Auch Zwangserkrankungen gehören zu den häufigeren psychischen Störungen. Sie weisen viele Parallelen zu den in 3.4. besprochenden Angsterkrankungen auf. Gemeinsames Merkmal aller Zwangserkrankungen ist, dass die Betroffenen um die Unsinnigkeit der Inhalte wissen und diese dennoch durch eine als irrational erlebte Angst aufrechterhalten werden.
Häufige Inhalte sind Sauberkeit (etwa die Angst vor Krankheiten und Infektionen) und Kontrolle (etwa die Vorstellung, durch Unordnung Dinge zu gefährden oder mit offenen Türen Einbrüche zu riskieren).
Man unterscheidet drei Haupttypen der Zwangserkrankungen:
Bei den Zwangsgedanken handelt es sich um ausschließlich in der Vorstellung des Patienten sich ereignende Phänomen, wie etwa Zählzwänge und magische Gedanken, von denen man sich schwer lösen kann und die dadurch z.B. die Arbeitsproduktivität oder die Abläufe beeinträchtigen.
Zwangsimpulse haben dagegen eine imperative Komponente, man kann etwa daran leiden, sich zu aggressiven Handlungen gegen Angehörige gedrängt zu fühlen.
Dies geschieht wider besseres Wissen; in der Regel werden diese Impulse nicht ausgelebt; man kann also als Beobachter nichts “Objektives” sehen.
Äußerlich bemerkbar sind schließlich die Zwangshandlungen. Diese reichen von kurzen, Tic-ähnlichen Bewegungen bis hin zu ausgedehnten Ritualen.
Vor allem Zwangsrituale, die durch die Themen Sauberkeit und Kontaminations-/Infektionsangst geprägt sind, wirken sich fatal auf die Alltagsgestaltung und Lebensqualität aus. So gibt es Patienten, die stundenlang duschen und die Körperreinigung in einer ganz bestimmten Reihenfolge durchführen; schon die kleinste Abweichung zwingt zum Beginn ganz von vorne.
Ähnlich raumgreifend und zeitraubend wirken sich Rituale rund um das Thema “Sicherheit” aus: dies kann von vielfach wiederholten Kontrollen aller Türen und Fenster bis zur wiederholten Kontrolle von Wärmequellen und elektrischen Geräten reichen; solche Zwangshandlungen verzögern etwa das Verlassen des Hauses am Morgen und den Weg zur Arbeit.
Menschen mit Zwangserkrankungen sind ihre eigenen Handlungen in der Regel peinlich, da sie ja dem Individuum als “unsinnig” bewußt sind, ohne daß man davon loskäme: daher werden die Probleme oftmals verschwiegen und mit teils großem Aufwand “getarnt”.

Auch für Zwangserkrankungen gilt, dass sie im Prinzip gut behandelbar sind; nach einer erfolgreichen Behandlung verbleiben ähnlich wie bei Angsterkrankungen keine Defizite und dauerhaften Einschränkungen. Allerdings kommt es oft noch nach Jahren zu Rückfällen, bei denen möglicherweise ein verändertes “Thema” auftaucht.
Die psychotherapeutische Behandlung, ähnlich wie bei Angsterkrankungen in Form einer kognitiven Verhaltenstherapie, ist in der Mehrzahl der Fälle erfolgreich; die am besten wirksame Methode ist die Exposition etwa mit dem “Verschmutzungsreiz” oder dem Verlassen des Hauses; es wird dann unter therapeutischer Anleitung jeweils die (pathologische) Reaktion verhindert. Ein Patient soll sich etwa nach dem Berühren einer Türklinke oder dem Besuch einer öffentlichen Toilette nicht dem Impuls zu intensiver Wäsche und Desinfektion hingeben, muß aus der Wohnung den Bus zum Arbeitsplatz nehmen, ohne noch einmal den Herd zu kontrollieren usw.. Die dadurch ausgelöste Angst und deren körperliche Begleitsymptome klingen dann physiologisch ab, so dass die oft katastrophisierenden Erwartungen entkräftet werden. Für viele Menschen mit einem eher chronischen oder sehr schweren Zwangserleben oder -verhalten können bestimmte Antidepressiva mit Erfolg eingesetzt werden.

Auch für Zwangserkrankungen existieren Faktoren, die einer Chronifizierung und Ausweitung der Symptomatik Vorschub leisten. Diese aufrechterhaltenden Faktoren liegen neben Mängeln im Versorgungssystem (Mangel an qualifizierten Psychotherapeuten, Anwendung ungeeigneter Therapieverfahren) auch im persönlichen Bereich: Da Zwangssymptome “angstgesteuert” sind, ist nicht für jeden Menschen Therapie “attraktiv”; oftmals werden Behandlungsangebote vermieden. Anders als Angsterkrankte verschweigen Zwangserkrankte in der Regel ihre Problematik, so dass die Menschen häufig in Isolation geraten.

Im Arbeitsleben führen Zwangserkrankungen in ungünstigen Fällen ebenfalls zu langen Krankschreibungen und Arbeitsunterbrechungen; das reine “Abwarten” der Krankschreibung führt ohne spezifische Intervention nicht zu einer Verbesserung der Situation.

Wenn Menschen mit Zwangserkrankungen in das Arbeitsleben zurückkehren, ist das zugrundeliegende Prinzip wir bei Angsterkrankungen das der Normalität. Zwangserkrankungen hinterlassen keine Dauerschäden oder Fähigkeitseinschränkungen; bei ehemaligen Zwangspatienten gibt es keine Ausschlüsse bestimmter beruflicher Tätigkeiten.

Wenn ein Jobcoach als persönliche Assistenz im Arbeitsleben installiert wurde, sollte er sich daher möglichst bald “überflüssig” machen; eine Dauerassistenz aufgrund einer Angsterkrankung ist kontraproduktiv.
Ein Jobcoach kann für Kollegen und Arbeitgeber aber eine wichtige Rolle spielen, indem er – immer in Absprache mit dem Betroffenen- auf arbeitsplatzbezogene Faktoren einer- und konkrete Hilfsbedarfe andererseits hinweist bzw. diese selbst entwickelt. Wenn ein Zwangskranker etwa Schwierigkeiten hat, Arbeitsprozesse abzuschließen, kann eine externe Vorgabe zur Bearbeitungszeit oder ein aktiver “Eingriff” hilfreich sein, mit dem der Vorgang aus der Zuständigkeit des Betroffenen herausgenommen wird.

Für Jobcoaches sind daher in der Begleitung an Zwangserkrankungen leidender Menschen folgende Aspekte von Bedeutung:
Zur Erkrankung:
-handelt es sich um eine wiederkehrende Erkrankung ?
-ist die betreute Person in psychiatrischer und psychotherapeutischer Behandlung ?
Zum Arbeitsalltag:
-gibt es am Arbeitsplatz Faktoren, die in der Vergangenheit Anlaß oder Auslöser von Zwangsgedanken, -impulsen oder -handlungen waren ? Dies können etwa sanitäre Anlagen sein.
-Finden Zwangssymptome Eingang in den beruflichen Alltag; ist ein Betroffener z.B. nicht in der Lage, einen Vorgang abzuschließen, weil er immer und immer wieder kontrollieren muß, ob nicht doch ein Fehler vorliegt ?
-sind Arbeitgeber, Vorgesetzte, betriebliche Gesundheitsdienste und Kollegen über die Erkrankung informiert und wenn ja, in welchem Umfang ?

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4. Outlook

(short remark as to other products and their availability and to national curricula)